



For Official Use Only

Date Received: _____

Rec. Number: _____

Expiration Date: _____

Comments: _____

Application for Individuals to Conduct Asbestos Activities

Please type or print responses in black or blue ink.

A. Type of Certification Requested

Select one of the following:

- ☐ Initial (first-time) certification ☐ Re-certification ☐ Replacement of lost card

Indicate the discipline(s) for which you are seeking certification or re-certification:

- ☐ Inspector ☐ Worker ☐ Contractor/Supervisor ☐ Project Monitor
☐ Project Designer ☐ Management Planner

B. Applicant Information

Name: _____
Last First Middle

Social Security: _____ Date of Birth: _____ Sex: M F
Month/Day/Year circle one

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____
Feet Inches Pounds

Race/Ethnicity: _____
(optional)

Home Address: _____
Street Address, Apt. # City State Zip Code

() _____
Phone Number

Business Information: _____
Name

Street Address, Suite # City State Zip Code

() _____ Ext. _____
Phone Number

C. Education

High School: _____
Name Location Highest Grade Completed

Name any technical, vocational, or special trade schools, colleges, and/or graduate schools you have attended. Indicate highest level completed, major course of study, degrees received, and year graduated, if applicable. Attach additional sheets of paper if necessary.

School	Course of Study	Highest Level Completed	Degree(s) Received	Year Graduated

D. Experience

Complete the following items about your experience if you are applying for **contractor/supervisor, inspector, management planner, project designer, or project monitor** certification or re-certification. Attach additional sheets if necessary.

Title or Occupation: _____ Supervisor's Name: _____

Business Name: _____
Name

Street Address, Suite # City State Zip Code

Business Phone #: (____) _____ Period of Employment: _____
From To

E. Training

Complete the following items about the training you received in the discipline(s) for which you are seeking certification or re-certification. Attach additional sheets of paper if necessary.

Name of Initial Training Provider: _____

Name of Initial Training Center: _____

Initial Training Center Address: _____
Street Address, Suite # City State Zip Code

Initial Training Provider Phone #: (____) _____ Course Completion Date: _____
MM/DD/YY

Initial Training Certificate #: _____

Please check the type of test you took: ☐ Course Test ☐ Hands-on ☐ Proficiency Test

Name of Refresher Training Provider: _____
(Most Recent)

Name of Refresher Training Center: _____

Refresher Training Center Address: _____
Street Address, Suite # City State Zip Code

Refresher Training Provider Phone #: (____) _____ Course Completion Date: _____
MM/DD/YY

Refresher Training Certificate #: _____

Use the following if applying for more than one discipline:

1. Name of Initial Training Provider: _____

Name of Initial Training Center: _____

Initial Training Center Address: _____
Street Address, Suite # City State Zip Code

Initial Training Provider Phone #: (____) _____ Course Completion Date: _____
MM/DD/YY

Initial Training Certificate #: _____

Please check the type of test you took: ☐ Course Test ☐ Hands-on ☐ Proficiency Test

Name of Refresher Training Provider: _____
(Most Recent)

Name of Refresher Training Center: _____

Refresher Training Center Address: _____
Street Address, Suite # City State Zip Code

Refresher Training Provider Phone #: (____) _____ Course Completion Date: _____
MM/DD/YY

Refresher Training Certificate #: _____

2. Name of Initial Training Provider: _____

Name of Initial Training Center: _____

Initial Training Center Address: _____
Street Address, Suite # City State Zip Code

Initial Training Provider Phone #: (____) _____ Course Completion Date: _____
MM/DD/YY

Initial Training Certificate #: _____

Please check the type of test you took: ☐ Course Test ☐ Hands-on ☐ Proficiency Test

Name of Refresher Training Provider: _____
(Most Recent)

Name of Refresher Training Center: _____

Refresher Training Center Address: _____
Street Address, Suite # City State Zip Code

Refresher Training Provider Phone #: (____) _____ Course Completion Date: _____
MM/DD/YY

Refresher Training Certificate #: _____

3. Name of Initial Training Provider: _____

Name of Initial Training Center: _____

Initial Training Center Address: _____
Street Address, Suite # City State Zip Code

Initial Training Provider Phone #: (____) _____ Course Completion Date: _____
MM/DD/YY

Initial Training Certificate #: _____

Please check the type of test you took: ☐ Course Test ☐ Hands-on ☐ Proficiency Test

Name of Refresher Training Provider: _____
(Most Recent)

Name of Refresher Training Center: _____

Refresher Training Center Address: _____
Street Address, Suite # City State Zip Code

Refresher Training Provider Phone #: (____) _____ Course Completion Date: _____
MM/DD/YY

Refresher Training Certificate #: _____

F. Professional Certifications

In the following blanks, list professional certifications held, such as, Industrial Hygienist, Professional Engineer, Registered Architect, Environmental Scientist. Attach additional sheets of paper if necessary.

Certification	Area where registered
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Certification	Area where registered
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If you hold current permits, licenses, certifications, or registrations in the asbestos field in any region or area, please fill in the following blanks. Attach additional sheets if necessary.

Discipline in which certification held	Area/Region	Cert. #/ ID #	Date Received
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Discipline in which certification held	Area/Region	Cert. #/ ID #	Date Received
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G. Asbestos Activity Violations

Do you have any past or pending asbestos activity violations? ☐ Yes ☐ No

If **yes**, please attach a written explanation of circumstances, outcome, and action taken to remediate the problem.

H. Additional Information

Please attach any additional documentation if you have other qualifications or information that you would like the Department to be aware of.

I. Signature

Please sign your name and write the date in the blanks below if you understand and agree with the following statement:

I hereby attest and affirm that the information included on this application, including any attachments, is true and accurate to the best of my belief and knowledge. I acknowledge that any certification issued pursuant to this application, including any attachments, will be subject to revocation if issuance was based on incorrect or inadequate information that materially affect the decision to issue the certification. I also attest and affirm that I will maintain my certification(s) according to Hawaii Administrative Rules §11-504-4, follow work practice standards according to §11-501, and conduct asbestos activities only in those fields in which I have received certification.

Applicant's Signature

Date Signed

Applicant's Title

J. Checklist

Before you submit your application, please check to make sure that you have:

- | | |
|--|---|
| <input type="checkbox"/> Filled out all sections completely | <input type="checkbox"/> Enclosed any additional documentation |
| <input type="checkbox"/> Signed and dated the application | <input type="checkbox"/> Enclosed the appropriate certification fee |
| <input type="checkbox"/> Enclosed the <u>original</u> course completion certificate(s) | <input type="checkbox"/> Enclosed documentation of your education, experience, and professional certifications <i>(if needed)</i> |
| <input type="checkbox"/> Made a copy of entire application along with any attachments for your files | <input type="checkbox"/> Called (808) 586-5800 to request an appointment |

Submit original completed application, all supporting materials, and fees to:

STATE OF HAWAII
DEPARTMENT OF HEALTH
INDOOR AND RADIOLOGICAL HEALTH BRANCH
ASBESTOS SECTION
591 Ala Moana Boulevard, Room 133
Honolulu, HI 96813
Telephone #: (808) 586-5800

Please make checks payable to **STATE DEPARTMENT OF HEALTH**. There will be a \$25.00 service fee for any check dishonored by the bank.

- ❖ Your original course certificate(s) will be returned to you after we make a copy

Please call (808) 586-5800 to schedule an appointment for I.D. card issuance or for further assistance.